

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 22, 2004
10:09 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
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ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Hospice care in Medicare: Recent trends and a review of the issues -- Cristina Boccuti, Sarah Thomas

MS. BOCCUTI: Good afternoon. In this presentation I'm going to review a few of the points that Sarah raised in the last meeting and note some growth trends in the hospice provider community. Then I'm going to discuss some payment refinements that have been proposed, and finally, I'd like to leave plenty of time for the Commission to discuss these issues and comment on the draft chapter.

In brief, hospice is a set of palliative care benefits for terminally ill beneficiaries with a prognosis of six months or less to live if their illness runs an expected course. The services covered within the hospice benefit includes skilled nursing, therapy, home aide, homemaking, some physician services, nutrition counseling, medical social services, bereavement and pastoral care, respite care, prescription drugs, DME, and medical supplies. These services may only be provided for palliative indications because beneficiaries who elect hospice care must forego curative treatment for their terminal illness. However, Medicare continues to cover curative care for conditions unrelated to the terminal illness.

Once a beneficiary enrolls in hospice care, the agency caring for the patient is paid a fixed amount daily for that patient regardless of how often an agency staff person visits the patient. 95 percent of payments are made at the routine health care level. The remaining 5 percent of payments are higher and are made when patients are receiving inpatient care, continuous health care, or respite care.

There are two kinds of payment caps. Although most agencies do not receive them, some agencies have publicly noted in their investor reports that they've exceeded Medicare's total annual payment cap, which in 2003 was about \$18,700 per served beneficiary. The hospice payment system has no outlier payments. It also has no case-mix adjustment. Under current law daily payments are automatically updated annually based on the hospital marketbasket.

Growth in the use of the hospice benefit has been substantial. Among fee-for-service beneficiaries who died hospice has grown from about 16 percent in 1998 to 25 percent in 2002. The average number of days in hospice, which is generally the number of days beneficiaries are in hospice before they die, has increased to 55 days. The median, however, has remained constant due to the steady share of beneficiaries who are in hospice less than a week.

Recalling Sarah's presentation last month, growth in hospice use has been greatest among several types of beneficiaries, those that are the oldest, those with non-cancer diagnoses, and those who reside in nursing facilities. It seems clear that in many cases we're talking about the same patients. That is, beneficiaries who reside in nursing homes are more likely to be older and have terminal illnesses other than cancer, and with all these factors have a longer length of stay.

Finally, with more people enrolling in hospice and having longer hospice stays on average Medicare spending on hospice has increased substantially. CMS's Office of the Actuary estimates Medicare outlays to have doubled between 2000 and 2003.

So the growth in hospice can be due to several factors. First, there appears to be an increase in the demand for hospice care. It's a form of care appropriate for the dying population and beneficiaries and physicians are likely accepting and appreciating it more. Indeed it was in past years, and likely still is, underused by Medicare beneficiaries with terminal illness. CMS

has also made efforts through publications to physicians to promote the use of hospice care by appropriate beneficiaries.

Second, new provider entry into the market, which I'll get to in a minute, indicates that the financial environment for providing hospice care is likely very favorable.

This table on this slide shows the types of hospice providers in the industry. As you can see, not-for-profit programs remain the largest share of the industry but their share has dropped slightly each year. Moving down to the hospice types, we see four types: freestanding, home health, hospital and SNF-based. I want to make it clear here that the term freestanding is sometimes a bit of a misnomer. It does not necessarily indicate that it's a brick and mortar freestanding building. But rather it means that the hospice is not based on another type of provider. Also for clarity, hospital-based facilities do not necessarily provide care in a hospital. They're simply owned by a hospital and may provide services in patient homes. Freestanding facilities compose the largest share of hospice agencies as most for-profit agencies are freestanding hospices.

Just as the number of beneficiaries using hospice has increased, so has the number of hospices. As you can see in this slide, the number of for-profit facilities has grown 25 percent, significantly more than facilities with other types of ownership. Freestanding facilities have also shown considerable growth. CMS collects this kind of data on an ongoing basis and they reported to us that growth in 2004 is continuing along these same trends. CMS stated to us that provider growth is primarily due to new facilities entering the market.

However, some investor reports and articles in the business trade press have noted acquisition of not-for-profits by for-profits. Keep in mind that because hospice benefits are usually provided in patients' homes, the hospice industry can also grow through increases in its capacity. We have found that the number of high-volume hospice agencies is increasing while the number of low-volume hospices is declining.

This final slide lists an array of policy options and considerations that have been proposed by various scholars and organizations including MedPAC in the past. First here we have case mix. Case-mix adjustments attempt to refine provider payments to reflect the costs for furnishing services to a given inpatient. In doing so, case-mix adjustments can improve access to care for patients with high cost care needs. Because the hospice payment system does not have a case-mix adjustment, hospices have financial incentives to enroll patients whose costs are expected to be low and deny enrollment to those with high expected care costs.

An article that was published in last week's Journal of the American Geriatric Society revealed that some hospices deny admission based on indicators that they may have high service costs. Specifically, 63 out of 100 California hospices surveyed in this study denied admission based on at least one reason. Reasons for denying patient admissions included their receiving total parental nutrition, or receiving tube feedings, or radiotherapy, or chemotherapy, or transfusions, or lack of a caregiver in the home. This study found that the larger the hospice, the less likely they were to deny admission based on these kinds of criteria.

Hospice representatives also told us that agencies which do not feel that they have the resources to care for a patient do sometimes deny enrollment. Indeed, some expensive services such as chemotherapy were not factored into hospice cost estimations when the benefit was first established because they were not used in a palliative way. Costs for the hospice benefit have not been recalibrated to reflect any changes in hospice care practice patterns.

Next we have length of stay. Payment adjustments related to length of stay have also

been suggested. Agencies with shorter lengths of stay have higher average daily costs because the initial and the first day are most costly. Some have suggested special payments for the first and last day of care. This could potentially be paired with payment adjustments from long hospice stays.

MedPAC analysis has found that patients in for-profit facilities have, on average, longer lengths of stay than those in not-for-profit facilities.

Next on the list, rural adjustment. Another article published last week confirms other studies which find that urban areas have higher rates of hospice use than rural areas. Rural hospices also have lower volume on average than urban hospices. This low volume may raise hospices' cost per case and some have suggested that Medicare payments should account for these differences.

Type of residence. Some observers have noted that hospice care for patients in nursing homes may be less costly than for patients who live at home. The industry has noted, for example, that a hospice can save on transportation cost when serving several patients within the same nursing home.

For dually eligible patients, hospice agencies receive payments from both Medicaid and Medicare. The hospice then contracts with the nursing facility to provide the room and board. Further research on service costs and total payments for hospice patients in nursing facilities may inform payment refinement for this population.

Outlier payments. Outlier payments have been suggested to cover the cost of patients with unusually high service costs. Along the same lines as case-mix issue, outlier payments could assist with access to care for patients on expensive therapies such as palliative chemotherapy. Hospices are paid on a per-diem basis but there are no visit number requirements as long as the hospice follows the patient's plan of care. It might be useful for Medicare to collect more data on the number content of visits per patient as it does with home health delivery. This information would address provider accountability concerns and also help Medicare understand the cost of providing hospice care.

And then to quality. Another area which the Commission may want to explore is quality improvement and reporting. Updating Medicare's conditions of participation to include quality measurement and quality improvement activities could be helpful. Most agencies seek accreditation and in doing so meet quality improvement requirements. As in other provider settings, the results of quality measurement could be reported publicly through a Medicare initiative. Some quality measures that some hospice providers are using include whether the patient was comfortable or had effective pain management, and whether the patient's choice of place of death were followed.

Under eligibility, some experts have noted that the six-month prognosis requirement can be a barrier to accessing appropriate hospice care. That is, people who wish to give up all curative care for their illness are unable to enter hospice if their physician feels unable to predict their death accurately. Some have suggested that hospice eligibility take acuity levels into account and diagnoses as well so that people with terminal illnesses that have less predictable diagnoses could receive the advantage of hospice care before it's too late to benefit fully.

Finally, managed care. Last month, Sarah discussed the payment issues surrounding hospice care for beneficiaries in managed care. In review, beneficiaries who elect hospice care must receive their palliative care from a hospice agency rather than from their managed care plan. Plans receive a reduced monthly payment for hospice patients but are no longer at risk for all

their Medicare-covered benefits. This payment circumstance deters plans from developing and providing palliative care and encourages a disruption in the patient's care. Some managed care plans have begun developing innovative end-of-life care programs but Medicare's payment policy does not support the use of such programs. This payment structure has also been found to increase Medicare costs and add a high level of administrative complexity to plan payments.

That concludes my presentation. I would be happy to answer any questions.

DR. WAKEFIELD: You mentioned earlier in your comments that your data show that the number of low-volume hospices is declining. Do you have a sense of where those low-volume hospices are in terms of geographic distribution? So in other words, are they in places where you already have maybe one or two or three other alternatives available in a large urban area with a higher volume of hospice services, or do you have a sense that some of those or a lot of them might be low-volume hospices that exist in rural areas, so that we might be losing access to that set of services more broadly to -- albeit sparse, but to populations nevertheless?

I was interested in your comment about the fixed overhead low volume issue. You cited some article that have been published recently about that. Obviously we've looked at those relationships before in terms of making recommendations about refining payment policies to better align them, given those circumstances and the hospital care. So I'm interested in that point as well. But for starters, any descriptive info on the geographic distribution.

MS. BOCCUTI: I wish I could, and I'll try and look for it in other places. The place where I got the information on declining enrollment low-volume and increasing enrollment in high-volume hospices, or the number of hospices. It's not enrollment -- is from the Federal Register listing. While it's broken down urban, rural, it's not cross-tabbed that way so I can't figure that out. But I'll look in other areas. I think that the article that I brought up doesn't look across time, but I'll look at that again to see whether there's a decline.

But I bet that if I look a little harder I could come up with some of that or talk a little bit further with CMS, because they have the data and we have to figure out what to ask for and how to get it. So I can look into that. Did that answer your second question as well?

DR. WAKEFIELD: It did.

MS. BOCCUTI: It's not a situation where I can say that it's impossible to get.

DR. WAKEFIELD: Even on the issue of low volume, you may not be able to go there either.

DR. ROWE: This was very interesting and I think we're making real progress. I have a couple points, some of which I've said before but just to reiterate.

First of all, I think the data and the information on length to stay deserves a little more analysis. You say that the length of stay went up to 55 days in 2002. The table 6.3 shows it at 52 days.

MS. BOCCUTI: It should be 55.

DR. ROWE: But even if it is up to 55 and you say the median is constant, the median is actually declining from 18 to 17 to 16, and the 25th quartiles is about the same. So really the point is here that there are an increasing number of very long stay, and that's what's going on. The 25th quartile is about the same. So I think it's worth just giving people a little bit more information about that so they don't have to connect all the dots themselves, because they headline otherwise is going to be, average length of stay increasing, and it's artificial. There are a small number of people who have very long stays, and that's a good thing I think. But it's just a little more information.

The second thing is, I don't believe we should have a cap, a monetary cap on a benefit that we all agree the greater use of it is better. There is cognitive dissonance for me when we say we want to increase the length of stay in hospice and then we have a benefit that has a financial cap. Because what you are going to do is have more and more people get up to the cap just before they die and then get kicked out of the hospice. So it just doesn't make any sense to me, if I understand that there is in fact indeed a financial cap. So I would need to understand better how that works. But to have a slide that says there is a financial cap and --

MS. BOCCUTI: Let me say a couple things about the cap. You're right, we haven't gone into a policy analysis about the use of the cap. It came with the benefit when it was first established to allay concerns about it going widely out-of-control and being a budget issue. It is not common to hit the caps, but it is happening.

DR. ROWE: I would think it's happening with that small proportion of the people with the very long stays that are bringing up the mean.

MS. BOCCUTI: It's for one agency. It's on an agency by agency basis, and it's their total number of patients. So it's not an outlier.

DR. ROWE: I see. Maybe that was described in detail. I missed it.

MS. BOCCUTI: So what it's saying is if an agency hits the cap then their payments have exceeded the cap.

DR. ROWE: I interpreted it, and I may not be the only one, as a benefit cap on a beneficiary, so I apologize.

I would agree that the managed care situation is archaic and I think managed care companies are just going to go develop better programs with respect to care at the end of life. To whatever extent you want more Medicare beneficiaries in managed care, that will be a problem. But I would agree with that.

I do think that the last thing I'll say and we said this before, the six months requirement, which is basically asking people to walk through a door that says over it, abandon hope all ye who enter here, is not the way people think about themselves and their lives. A hundred years ago when I was practicing medicine I would say to people, you're not responding to these treatments. It doesn't mean we won't keep trying. I'm talking to my colleagues. Some other things may come up and we're going to do everything we can, but it's time to start thinking about what if you don't respond, and there are things that you should be thinking about and talking with your family about, and there are other approaches to treatment that you might find helpful. You don't just say, sign this paper.

MS. BOCCUTI: That is a unique eligibility requirement to the Medicare hospice program. In private plans they don't often require that kind of a signature.

MR. HACKBARTH: Here again, it was a provision that was added I think strictly out of fear of the cost. Sheila will know all of this firsthand.

MS. BURKE: Let me just go back to '83 when we did this. The challenge at the time was that we really didn't understand nor fully appreciate how people would experience this benefit and how the benefit would be utilized. There was little experience in this country. Connecticut was one of the few places where it was occurring. We looked to Great Britain for essentially a lot of the stuff that was coming out of there, and there were a number of fears.

One, there were tremendous fears about drugs. There was this great issue we were going to create an entire nation of heroin addicts. There was a tremendous fear but what we didn't know about palliative care.

Secondly, there are a concern that people would bounce. That they would choose this without acknowledging that they were making a choice about this as compared to curative care. There was a sense at the time that people had to in fact -- that you needed to encourage people to make those decisions. It was a crude way of doing that.

We also didn't really know what the timeframe was, whether it was six months, whether it was two months, whether it was a week, whether it was eight weeks. So what you've seen over the years is a growing acceptance of that as a method of care and a willingness to essentially make these transitions, although the lengths of stay are still too short. People tend to choose to late, for one of the reasons you suggest, which is people hold out hope. People want to know that there is in fact that opportunity, and making that transition, making the decision between seeking curative care and accepting and making a decision to seek supportive care is a very difficult one, so people don't make it, as you know better than anyone.

So it was at the time an attempt to get a benefit in place with little understanding of how people would use it, and trying to control the fear around what the cost would be, what the utilization would be, who would choose it, why they would choose it. And also, that you wouldn't literally have people this week do hospice, next week decide they want to go back in traditional care. So it was trying to create an environment in which that bounding didn't take place.

We are way beyond that, and the refinements that are suggested here, and a greater appreciation and understanding clearly is what has to happen. But it was done with the best of intentions given how little we knew and our intention to do the best we could with what we knew at the time.

MS. RAPHAEL: I think there is something else that happened and it is not as prevalent today, but in the last five to six years there has been a lot of OIG reviews of the six-month requirement and a number of hospices were cited for having cases that didn't fit in because the physician had not prognosticated accurately, which is very difficult to do anyway. I think that has had a chilling effect which takes a longer time to dissipate than one would think, even though that has receded and there's been a CMS proclamation, go forth and don't be inhibited by this unduly. I still see a lot of hospices being very skittish about this particular requirement. So it's almost become a more forceful part of the program in the last few years.

MR. HACKBARTH: Do we have sufficient information from outside the Medicare program, whether it's private payers or other countries, whatever, at this point, that we could say this requirement can be eliminated without dire consequences, financial or otherwise?

DR. ROWE: I've been looking at this recently and I don't believe so. I think that what happened for a long time is many health plans followed Medicare's policies with their eligibility requirements, as they do with respect to coverage of things. It's easy to defend and who knew to do it differently. Now people at least in our firm are starting to look at this a little differently. I don't think we've accumulated enough experience, but I think a reasonable policy recommendation would be to change the six-month requirement on the part of physicians to 12 months. Twelve months is really very different and a might relieve some of the concerns that Carol has just indicated.

I think that there could be a statement about the fact that curative care could continue to be offered but some recognition of the fact that you're in a different stage. But this business about promising never to ever let anybody give you anything that might be interpreted as curative is just too much to ask people. I'm sure there are people in the field, and I'm not in the field, who

have experience with this. But I do think these recent cases have been a problem and I think 12 months would give us a lot more room.

MS. BURKE: I think there are a number of pieces in this. One is the piece in terms of the determination that you are seeking palliative as compared to curative care and that conscious decision to sign off. The second is the cap. The third is the six-month. You could imagine modifying one of those without putting the others at risk.

For example, you could go to 12 months, leave the other pieces in place and begin to understand adjustments to that and still probably not run the risk of the program or the benefit going out of control. The question is which of those pieces to move before you move the other to see what the result would be. If that's the great inhibitor at the moment, maybe doing that to 12 without removing the requirement they make a decision or the cap, or just the cap based on some better understanding of acuity, might be the way to begin to manipulate those pieces without great risk.

MS. RAPHAEL: There's been much more erosion of the demarcation between curative and palliative and I think we've dealt with that. I don't think the cap is a major barrier from my knowledge nationally. I think the six-month is.

And one other point that you made I think is a barrier, which is if you don't have a family member who can participate, that is a barrier. We have many Medicare beneficiaries who are widowed and don't have a family member or don't have a child living in close proximity. Anyway, I think that we should focus on the six-month because I think that remains as the major issue.

DR. NELSON: Carol, you said that there has been erosion of the demarcation between curative and palliative. Would you clarify that for me? Use congestive heart failure as a case in point, where it might be damn hard to say what was palliative in terms of medication.

MS. RAPHAEL: Congestive heart failure is a problem for many reasons because you tend to have very great difficulty in predicting what the length of lifespan will be for congestive heart failure. That and Alzheimer's patients are the most difficult to predict. But I think in terms of using chemotherapy, it's no longer prohibited to do chemotherapy for people who are in hospice, and I think that's what I meant. So for cancer patients there's less of these barriers.

DR. ROWE: But regardless of whether or not Medicare prohibits it, you're still asking the patient to sign a document which says -- and I don't think that document has changed any in the last 20 years. So that's the barrier that we're concerned about, less than the clinical practice barrier. We need some advice about how to handle that I think.

DR. REISCHAUER: In a sense the length and the cap are redundant at some point. The longer you make it -- if you say it can be up to a year -- the more likely it is that the cap will be constraining rather than the days will be constraining. So I think in a way --

DR. NEWHOUSE: No, because you can keep going with successive periods of eligibility.

DR. REISCHAUER: But it's during a year. The cap is for a year, average payment per beneficiary over the year.

DR. NEWHOUSE: But as I understand it, the proposal was --

DR. REISCHAUER: If the average rate got up at 175 days from 55 days I think we'd hit the cap.

DR. NEWHOUSE: But as I understood it, it was just to ask the physician to certify that the patient would likely die within a year. But that doesn't necessarily mean that the average use

is going to go up. It puts the physician less at risk.

DR. REISCHAUER: You don't have to worry if the doesn't. But if you're fearful that extending that time is going to lead to growth in the average time span of beneficiaries, then I'm just saying that there is a connection between these two and you shouldn't get overly worried. Just keep one. Or I'm not that worried about your proposal is what I'm basically saying.

DR. ROWE: I'm not worried about worrying you about my proposal. Because you don't want to spend the money and I want the patients to be in the hospice.

DR. REISCHAUER: But we have to remember that the latest RAND study suggests that people who participate in this cost 12 to 18 percent more than those who don't.

MS. BOCCUTI: Depending on the diagnosis.

DR. ROWE: I thought it was 4 percent.

MS. BOCCUTI: That's overall. He had a different diagnosis in mind when he was saying that.

DR. ROWE: Actually what he had in mind was that I hadn't read the study.

[Laughter.]

DR. REISCHAUER: I thought you hadn't, and neither had I, but we could then have a conversation about it.

The other observation or question I'd like to ask you is, with the Medicare drug benefit going into effect, if we keep the payment system the same, in effect aren't we boosting the margins of these entities? Because one of the costs that they've been paying disappears or not?

MS. BOCCUTI: The per diem payment always was meant to cover the palliative care prescription drugs. Now if a patient has drug coverage it doesn't mean that they're going to go and get those drugs -- they might get them elsewhere, but the benefit still covers the drugs. So it's going to have covered it just as it did before the Medicare drug benefit.

DR. REISCHAUER: But I was thinking, if I came in and I was a member of this plan it wouldn't be paying for the drugs?

MS. BOCCUTI: No. It's my understanding that the hospice benefit would because that's always covered the drugs anyway.

The only issued to bring up relative to the drug benefit is that --

DR. REISCHAUER: So when you go into hospice then you have to stop paying your premium?

MS. BOCCUTI: Unless you want it for non-palliative care drugs.

DR. NEWHOUSE: Something else may happen to you that you can in fact curative care for.

DR. REISCHAUER: Is this going to be complicated.

MS. BURKE: The drugs in some cases are unique enough that they're unlikely to be on a formulary that you would use in the normal course. It depends on the nature of the drugs used in the hospice. If they're pain control, it would depend on what's in the formulary for the basic drug benefit. You may still need things that the hospice wouldn't in the normal course provide unrelated to your --

MS. BOCCUTI: Right, if you have gout or --

MS. BURKE: Gout or any number of those things. That would still be under the drug benefit.

MS. BOCCUTI: Maybe this is what you're saying. The drug benefit, the person probably has higher cost sharing than what's in the hospice benefit. The hospice benefit is nil. So before

the Medicare drug benefit there was obvious financial advantage if the patient had a terminal illness, there might be some incentive for them to enroll in hospice to help with covering the oral pain medications, if they didn't otherwise have drug coverage. But that still may exist, and I have no data about the demand relating to a drug benefit. But that could still exist given that even if the person does have drug coverage it's still more financially beneficial to have their drugs covered in the benefit. So that's really the only interplay between the two.

MR. HACKBARTH: Any others?

Okay.

DR. ROWE: What are we going to do, make recommendations?

MR. HACKBARTH: Not at this point, but we'll take this up next year and in our next cycle and then make recommendations.